# THIRD PARTY LIABILITY (TPL) CHANGE FORM

## TPL CHANGE FORM OVERVIEW

**Background**

The eligibility sources are required to collect TPL information at the time of an initial or review interview and transmit this information to AHCCCS. However, this information often changes after the interview. AHCCCS developed a form that enables providers, health plans, and program contractors to report new or changed third party coverage information in an AHCCCS recipient's file.

**Impact**

Incorrect TPL information in a recipient's file can adversely impact the processing of claims. For example, assume that a recipient's third party coverage has been terminated, but the information remains in the recipient's file; when the provider submits a claim to AHCCCS, the claim will be denied because the erroneous information blocks the claim. Conversely, if TPL exists but it is not on the AHCCCS file, this erroneously increases expenditures by AHCCCS and health plans.

**When to Submit the Form**

The form should be submitted to AHCCCS whenever it is determined that third party liability information in a recipient's record is incorrect (new TPL to be added or old TPL changed or terminated). Notification to AHCCCS is required within 10 days of the known change.

**Resolution**

The problem is prevented when TPL data in the AHCCCS system is kept updated based on information received from a provider, health plan, program contractor, or eligibility source.

**Form**

Providers, health plans and program contractors should ensure that all required fields on the form (indicated by an asterisk) are completed. The person completing the form must include his/her name and phone number in case AHCCCS staff in the Division of Member Services (DMS) have any questions about the information on the form. Providers can direct questions to Mary Lee in DMS at (602) 417-4412.

# AHCCCS THIRD PARTY CHANGE FORM

**To: AHCCCS ADMINISTRATION**
**MFIS, Mail Drop 3600**
**801 East Jefferson**
**Phoenix, AZ 85034**

To help us update recipient information insurance data, please complete this form, sign, date and return it.

INSTRUCTIONS FOR COMPLETION: Please print or type. Fill in as much information as possible in the spaces below. An asterisk (*) indicates that the field is required in order to update AHCCCS files. See reverse side for detailed instructions.

COVERAGE BEING REPORTED:
New Medical Insurance ☐ Information is being **added** (Enter item #s_____)
Medical Insurance Terminated ☐ Information is being **corrected** (Enter item #s_____)

## INSURANCE INFORMATION

1. *Insurance Company Name or HMO Name:_____
2. *Insurance Company Address:_____
3. Insurance Company Contact:_____ 4. Phone #:_____
5. *Policy ID #:_____ 6. Group #:_____
7. *Begin Date:_____ 8. *End Date:_____
9. Policy Type (check one): Group ☐ Individual ☐ Hospital ☐ Medicare ☐ Other ☐
10. *Policyholder's Name:_____
11. Policyholder's Phone #: (_____) _____ 12. *Policyholder's SSN:_____
13. Policyholder's Employer:_____
14. Employer's Address:_____

## RECIPIENT INFORMATION

Please use back of form if more space is needed.

| 15. *Name | 16. *AHCCCS ID | 17. *SSN | 18. *DOB | 19. Relationship of Policyholder to recipient |
|---|---|---|---|---|
| | | | | |
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| | | | | |
| | | | | |

20. *Signature of person completing form:_____
21. *Health plan/program contractor/provider:_____
22. *Telephone #:_____ 23. *Date:_____

**AHCCCS THIRD PARTY COVERAGE FORM**

INSTRUCTIONS

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**A MEDICAL INSURANCE FORM SHOULD BE COMPLETED AND RETURNED TO AHCCCS WHENEVER MEDICAL INSURANCE OTHER THAN THE INSURANCE LISTED ON THE ROSTER IS AVAILABLE, OR INSURANCE AHCCCS HAS REPORTED TO THE HEALTH PLAN OR PROGRAM CONTRACTOR HAS TERMINATED, OR INFORMATION CONCERNING THE INSURANCE IS INCORRECT.**

CHECK THE BOX INDICATING THE REASON THE FORM IS BEING SUBMITTED TO AHCCCS.

1. Enter the name of the insurance company or Medicare HMO.
2. Enter the insurance company's street address, city, state and zip code.
3. Enter the insurance company's contact person's first and last name, if applicable.
4. Enter the insurance company's 10-digit phone number (including area code).
5. Enter the insured member's policy number.
6. Enter the insured member's group number, if applicable.
7. Enter the policy begin date (month, date and year).
8. Enter the policy end date (month, date and year), if applicable.
9. Check the box indicating the appropriate policy type.
10. Enter the policy holder's first name, middle initial and last name.
11. Enter the policy holder's 10-digit phone number, including area code.
12. Enter the policy holder's 9-digit Social Security Number.
13. Enter the policy holder's employer's name.
14. Enter the policy holder's employer's street address, city, state and zip code.
15. Enter the AHCCCS recipient's first name, middle initial and last name for those covered under the insurance policy.
16. Enter the AHCCCS recipient's 9-digit AHCCCS Identification Number. If not available, the recipient's Social Security Number must be inserted.
17. Enter the AHCCCS recipient's 9-digit Social Security Number.
18. Enter the AHCCCS recipient's Date of Birth (month, day and year).
19. Enter the relationship of policy holder to AHCCCS recipient; i.e., child, absent parent, guarantor, legal guardian, parent, self or other.
20. Enter signature of person completing form.
21. Enter the health plan/program contractor or provider name associated with the person completing the form.
22. Enter the area code and 7-digit phone number where the person completing the form can be reached.
23. Enter the date that the form was completed.